

The effect of state parity laws on how providers treat substance use disorder

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Substance use disorder (SUD) can cause significant stress not only for the individual but also for society as a whole. To combat the high cost of treatment, states have begun to introduce parity laws, which are laws designed to standardize health insurance coverage of SUD treatment. How treatment centers react to these parity laws is essential in understanding the public health and social costs of SUD on society. According to Johanna Catherine Maclean, Ioana Popovici, and Elisheva Rachel Stern in “[Health insurance expansions and provider behavior: evidence from substance use disorder providers](#)” (National Bureau of Economic Research working paper no. 23094, January 2017), following the passage of parity laws, providers are more likely to be selective about which patients they treat.

Both federal and state governments have made an effort to close the gap between coverage of SUD treatment and physical health benefits in private health insurance plans. In 2008 the federal government passed the Mental Health Parity and Addiction Equality Act, which expanded SUD treatment coverage. In 2014 the Affordable Care Act ordered private health insurance providers to offer SUD treatment as a required benefit. Overall, these parity laws had only a slight effect on SUD treatment use.

The study looked at data from the National Survey of Substance Abuse Treatment Services (N-SSATS) from 1997 through 2010. The Substance Abuse and Mental Health Services Administration describes SUD treatment centers as a hospital, a residential facility, or an outpatient facility that provides outpatient, inpatient, or residential treatment, detoxification, opioid treatment, and halfway-house services. The N-SSATS survey looks at a SUD treatment provider’s operations for 1 day twice a year. The selected day was the end of September and the end of March from 1997 through 2000. An employee from every known SUD provider completed the survey, which equaled about 158,000 providers per year.

The researchers’ regression models include variables that may influence a provider’s response to changes in SUD treatment coverage. First, the study notes the types of payment received: private insurance, public insurance, and self-payment (uninsured). Second, the study documents the number of annual admissions and total number of patients treated on the selected day. Third, the study includes state-level demographic variables such as gender, age, race, ethnicity, and education. In addition, the study controls for social policies: the state minimum wage, the maximum Temporary Assistance for Needy Families, the maximum Supplementary Nutrition Assistance Program, and the state Earned Income Tax Credit. Last, state population is controlled for with data from the U.S. Census Bureau, and monetary values are expressed in 2010 dollars.

The study finds that state parity laws decrease the likelihood of providers engaging in public insurance markets. Additionally, providers are likely to move into the private market after the passage of a parity law. Provider participation in Medicaid and other state insurance decreases after the passage of parity laws, while Medicare and military markets see little to no change. Significant increases in both admissions and number of patients treated do not appear until 3 or 4 years after the parity law is enacted. Although there are not enough data to confirm this, the increase in annual admissions appears associated with a decrease in length of stay at treatment centers, which may be related to selecting easier-to-treat patients. In conclusion, the passage of state parity laws moves SUD treatment providers to increase the number of annual admissions but also become more discerning of the patients admitted.